HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12

MED-QUEST DIVISION

CHAPTER 1728

QUEST-NET

Subchapter 1 General Provisions

Subchapter 2 Eligibility

Subchapter 3 Adults in QUEST-Net

SUBCHAPTER 1

GENERAL PROVISIONS

§17-1728-1 Purpose. This chapter describes the QUEST-Net Program which provides medical benefits to

certain medical assistance recipients who become ineligible for a QUEST-related program or the fee for service coverage for aged, blind, and disabled individuals. Provisions in section 17-1728-8 allow certain individuals who are not currently medical assistance recipients to apply by December 31, 1996 for QUEST-Net coverage. [Eff 03/30/96; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1728-2 Definitions. As used in this chapter:

"Adult" means a person who is nineteen years of age or older and is not a child under age twenty-one who is in foster care placement or is covered by a subsidized adoption agreement. A person eighteen years old who is not dependent on and does not live with a parent, caretaker relative, or guardian may be an adult.

"Benefit year" means the period from the first day of July of one calendar year through the thirtieth day of June of the following calendar year.

"Blind" means, in relation to an individual applying for or receiving medical assistance from the department, meeting the Social Security Administration certification requirements for blindness.

"Capitated payment" means a fixed monthly payment paid per person by the department to a participating health plan for which the health plan provides a full range of benefits.

"Child" means a person under age nineteen who is dependent on and living with a parent, caretaker relative, or guardian. A person under age twenty-one who is in foster care placement or covered by a subsidized adoption agreement is also considered a child.

"Disabled" means, in relation to an individual applying for or receiving medical assistance from the department, meeting the Social Security Administration certification requirements for disability.

"Hawaii QUEST" means the demonstration project developed by the department which will deliver medical, dental, and behavioral health services through health plans employing managed care concepts, to certain individuals formerly covered by public assistance programs including the Aid to Families with Dependent Children (AFDC), related medical assistance programs, General Assistance (GA), and the State Health Insurance Program (SHIP).

"Health coverage carrier" means an insurance company or other organization which provides different health care benefit packages to one or more groups of enrollees.

"Non-returning plan" means a health coverage carrier that has a current, but no new contract with the department.

"Personal reserve standard" means the maximum amount of countable assets that may be held by an individual, a family, or a household while establishing or maintaining eligibility for medical assistance.

"Premium-share" means that part of the capitated rate that certain individuals, based on their income, are required to remit to the department to be eligible to be enrolled in a health plan participating in QUEST-Net.

"QUEST" means Hawaii QUEST.

"Spenddown requirement" means the dollar amount of monthly medical expenses which an affected person must incur, prior to receipt of medical assistance coverage from the department. [Eff 03/30/96; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1728-3 to 17-1728-5 (Reserved)

SUBCHAPTER 2

ELIGIBILITY

§17-1728-6 Purpose. This subchapter describes the eligibility requirements for participation in the QUEST-Net Program. [Eff 03/30/96] (Auth: HRS §346-14) (Imp HRS §346-14; 42 C.F.R §430.25)

§17-1728-7 Basic eligibility requirements. To be eligible for QUEST-Net, a person shall meet the basic eligibility requirements of U.S. citizenship or legal resident alien status, state residency, not residing in a public institution, and provision of social security numbers, as described in chapter 17-1714. [Eff 03/30/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-8 Categorical eligibility requirements. (a) When requesting coverage under QUEST-Net, a person shall be:

(1) A recipient of medical assistance either through a QUEST-related program or the fee for service coverage of aged, blind, and disabled individuals; or

(2) A person who would have been eligible for QUEST on the last day of the month prior to the implementation of the QUEST-Net program, except that aged, blind and disabled individuals were not allowed to participate in QUEST. A person who meets this criteria shall be allowed until December 31, 1996 to apply for QUEST-Net coverage.

(b) A person who is not eligible to participate in QUEST-Net includes a person who:

(1) Does not meet either of the requirements of subsection (a);

(2) Is not receiving medical assistance from the department either through a QUEST-related program or the fee for service coverage for aged, blind, and disabled individuals, when requesting conversion to medical assistance through QUEST-Net;

(3) Does not meet the financial eligibility requirements of QUEST-Net;

(4) Is eligible for Medicare coverage;

(5) Is employed and is eligible for coverage by an employer sponsored medical plan;

(6) Is eligible for medical coverage as an active military enlistee, a retired military personnel, or a dependent of an active or retired military enlistee;

(7) Is eligible for or enrolled in any medical plan at no cost to the person; or

(8) Is covered by a medical plan. [Eff 03/30/96; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-9 Financial eligibility requirements. (a) A person whose countable family assets exceed the personal reserve standard for a family of applicable size shall be ineligible for QUEST-Net.

(1) For a one-member family, the personal reserve standard shall be $5,000.

(2) For a two-member family, the personal reserve standard shall be $7,000.

(3) For family of more than two members, the personal reserve standard shall be $7,000 plus $500 for each additional family member.

(b) A person whose countable family income exceeds three hundred percent of the federal poverty level for a family of applicable size shall be ineligible to participate in QUEST-Net.

(c) A person's countable family income shall be determined in the following manner:

(1) For a pregnant woman and a child under nineteen years old who is born after September 30, 1983:

(A) Subtract a standard deduction of ninety dollars from the monthly gross earned income of each employed person; and

(B) Add the monthly net earned income for each employed person as well as any monthly unearned income to determine the countable family income.

(2) For all other family members, add the monthly gross earned income of each employed person and any monthly unearned income.

[Eff 03/30/96; am 07/06/99] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-10 Treatment of income and assets. (a) When determining financial eligibility for QUEST-Net, the provisions for treatment of income and assets in the Hawaii QUEST program shall apply.

(b) When determining financial eligibility for QUEST-Net, the definitions of financial support and responsibilities of Hawaii QUEST shall pertain.

[Eff 03/30/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1728-11 to 17-1728-13 (Reserved)

SUBCHAPTER 3

ADULTS IN QUEST-NET

§17-1728-14 Purpose. This subchapter describes the adults who are eligible to participate in

QUEST-Net, the benefits to be provided, enrollment provisions, and the financial responsibility of enrollees for coverage of health care costs. [Eff 03/30/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-15 Adults in QUEST-Net. (a) An adult who is eligible for QUEST-Net includes an adult who:

(1) Was either a former QUEST-related program or aged, blind, or disabled recipient and became ineligible because the adult does not meet the financial eligibility requirements of the QUEST-related program or aged, blind, or disabled programs;

(2) Voluntarily requested termination of a QUEST-related program or fee for service coverage;

(3) Was receiving coverage under a QUEST-related program but became ineligible as the adult was determined to be over age sixty-five, blind, or disabled and therefore categorically ineligible for the QUEST-related program; or

(4) Would have been eligible for QUEST on the last day of the month prior to the implementation of the QUEST-Net program, except that aged, blind, and disabled persons were not allowed to participate in QUEST. An adult who meets this criteria shall be allowed until December 31, 1996 to apply for QUEST-Net coverage.

(b) An adult eligible for QUEST-Net shall be enrolled in a participating medical plan for provision of covered medical services. [Eff 03/30/96; am 12/27/97; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-16 Standard benefits package. (a) A participating plan shall be required to provide certain benefits as defined in the contract between the plan and the department.

(b) The benefits minimally required of each participating plan shall be known as the standard benefits package.

(c) A participating plan may, at the plan's option, provide benefits which exceed the requirements of the standard benefits package. [Eff 03/30/96]

(Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-17 Hospital services to be covered by the plan. (a) Within a benefit year, a participating plan shall provide each enrollee a maximum coverage of ten days of medically necessary inpatient hospital care related to medical care, surgery, psychiatric care, and substance abuse treatment. The following hospital services shall be made available to each enrollee:

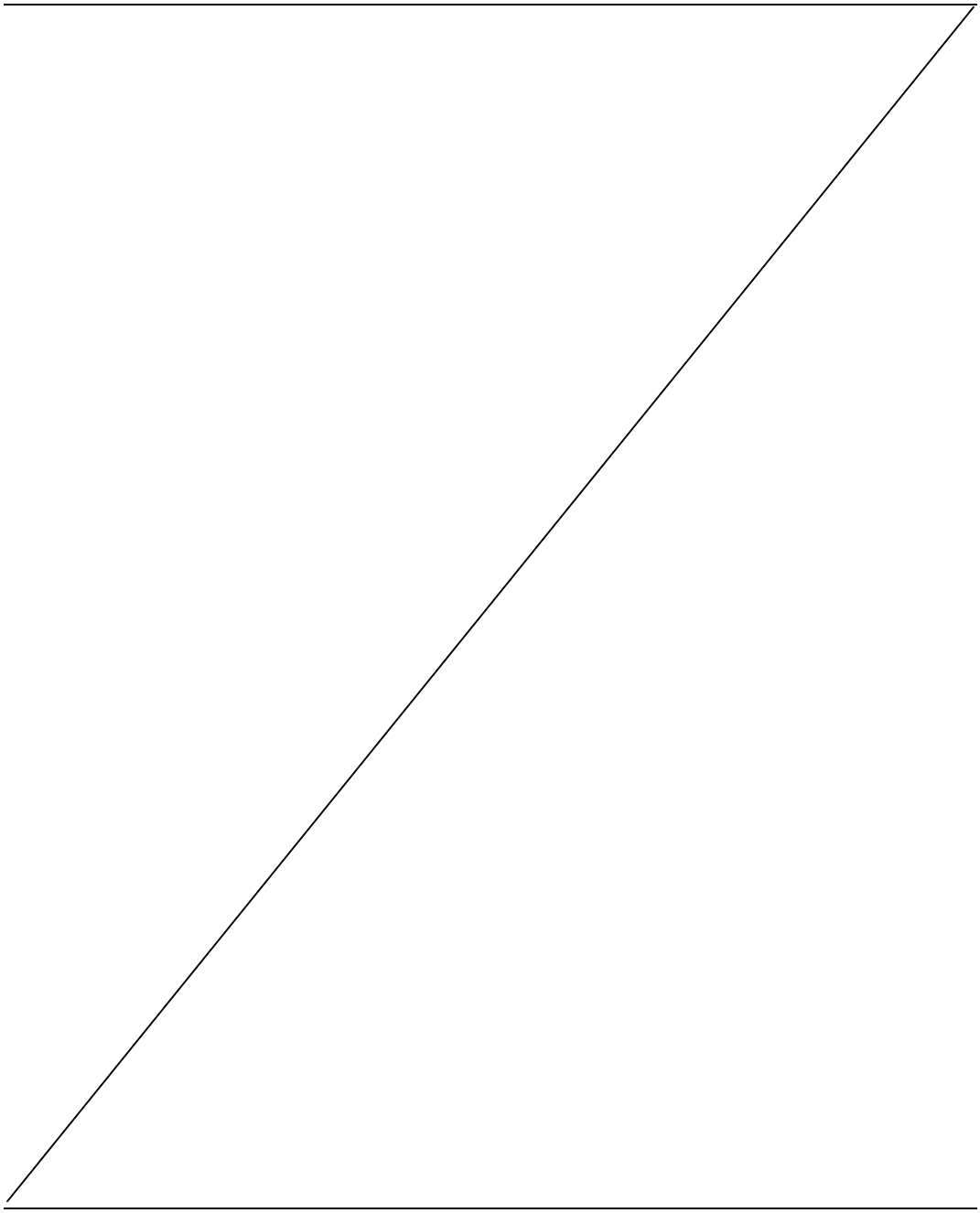
(1) Semi-private room and board and general nursing care for inpatient stays related to medical care, surgery, psychiatric care, and substance abuse treatment;
(2) Intensive care room and board and general nursing care for medical care and surgery;
(3) Use of an operating room and related facilities, inpatient anesthesia, radiology, laboratory and other diagnostic services agreed upon by the plan medical director for medical care and surgery;
(4) Drugs, dressings, blood derivatives and their administration, general medical supplies, and diagnostic and therapeutic procedures as prescribed by the attending physician;
(5) Other ancillary services associated with hospital care except private duty nursing; and
(6) Ten inpatient physicians visits within a benefit year.

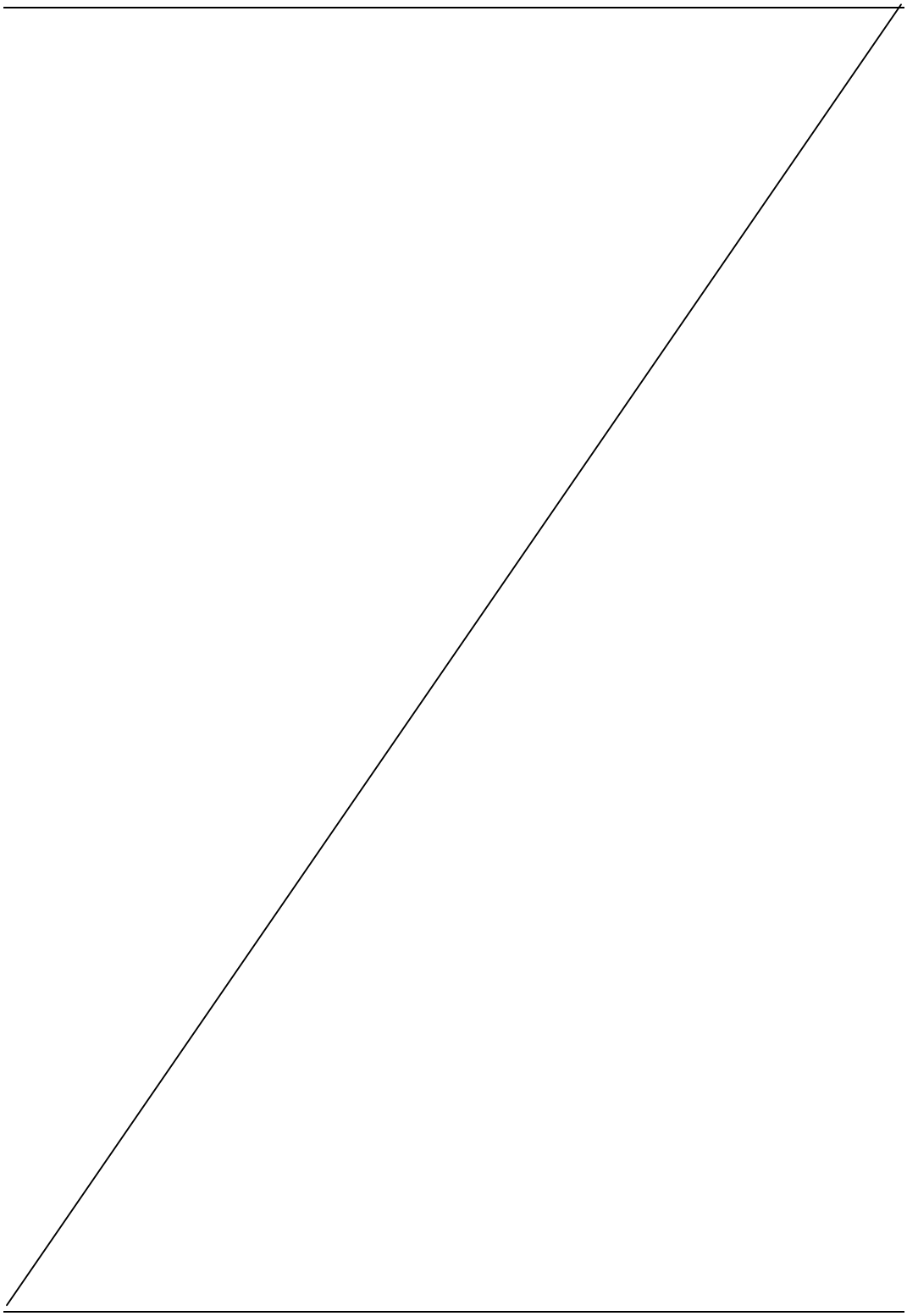
(b) Coverage of inpatient hospital care related to maternity, newborn nursery, neonatal intensive care, and inpatient services in a freestanding rehabilitation hospital shall not be required. [Eff 03/30/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-18 Outpatient services to be covered by the plan. (a) Within a benefit year, a participating plan shall provide each enrollee the coverage of the following outpatient services:

(1) A maximum of twelve outpatient visits including adult health assessments, family planning services, diagnosis, treatment, consultations, and second opinions. The

maximum of twelve outpatient visits shall not pertain to:
(A) Bonafide emergency room visits.
(B) An enrollee's first six mental health visits within a benefit year. After the





first six mental health visits, an enrollee may choose to apply a maximum of six additional mental health visits toward the maximum of twelve physician outpatient visits.

(C) Diagnostic testing, including laboratory and x-ray, directly related to a covered outpatient visit.

(2) Maternity care coverage shall be limited to one routine visit to confirm pregnancy and any visits for the diagnosis and treatment of conditions related to medically indicated or elective termination of pregnancy such as ectopic pregnancy, hydatiform mole, and missed, incomplete, threatened, or elective abortions. These visits shall count toward the twelve maximum outpatient visits, ten maximum inpatient days, or three maximum ambulatory surgeries.

(3) Coverage of medically necessary ambulatory surgical care shall be limited to three procedures per benefit year.

(b) For an enrollee age twenty-one or older coverage shall be provided for the following health assessments which shall be counted toward the maximum of twelve outpatient physician visits.

(1) An enrollee age twenty-one to thirty-five years old, inclusive, shall be allowed one examination within a period of five benefit years.

(2) An enrollee thirty-six to fifty-five years old, inclusive, shall be allowed one examination within a period of two benefit years.

(3) An enrollee over fifty-five years old shall be allowed one examination within each benefit year.

(4) An annual pap smear for a women of child bearing age shall be included in the health assessment for an enrollee age twenty-one or older.

(c) Coverage of immunizations for diphtheria and tentanus shall be provided.

(d) Coverage shall be provided for bonafide emergency room visits including ground ambulance, emergency room services, and physician services in conjunction with the emergency room visits. Bonafide emergency room visits shall be restricted to those requiring services for medical conditions manifesting

themselves in acute symptoms of such severity that the absence of medical attention could reasonably be expected to result in placing the enrollee's health in serious jeopardy, or serious impairment of bodily functions, or serious dysfunction of any body organ or part.

(e) Within each benefit year, each enrollee shall be provided a maximum coverage of six mental health visits, limited to one treatment per day.

(1) After exhausting the coverage of six mental health visits, an enrollee may use coverage of up to six of the enrollee's twelve outpatient physician visits per benefit year, as available, for additional mental health visits.

(2) Services for alcohol and substance abuse conditions shall be covered as mental health visits. The following restrictions on alcohol and substance abuse treatment apply.

(A) Outpatient alcohol or substance abuse services shall be considered toward the maximum coverage of six mental health visits and six annual outpatient physician office visits if used for additional mental health visits.

(B) Inpatient alcohol or substance abuse services shall be considered toward an enrollee's maximum coverage of ten hospital days.

(C) All alcohol or substance abuse services shall be provided under an individualized treatment plan approved by the plan.

(f) Coverage shall be provided for over-the-counter and prescription drugs limited by a strict formulary and defined in the contract negotiated between the plans and the department.

(g) Coverage shall be provided for family planning services to include family planning services rendered by physician or nurse midwife and family planning drugs, supplies and devices approved by the federal Food and Drug Administration.

(h) A participating plan may at the plan's option provide coverage of any service not required by the contract with the department, not covered under this section, or excluded under section 17-1728-17.

(i) Except for capitated payments to the plans, the department shall not be responsible for coverage of any service for any adult in QUEST-Net. [Eff 03/30/96;

am 11/25/96; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-19 Medical services not available to adults in QUEST-Net. The following services shall not be required to be covered by participating plans or the department for an individual age twenty-one or older in QUEST-Net:

(1) Custodial or domiciliary care;
(2) Services received in skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded;
(3) Personal care items such as shampoos, toothpastes, mouthwashes, denture cleansers, shoes including orthopedic footwear, slippers, clothing, laundry services, baby oils and powders, sanitary napkins, soaps, lip balms, and band-aids;
(4) Non-medical items such as books, telephones, electronic transmitting and paging devices, radios, linens, clothing, televisions sets, computers, air conditioners, air purifiers, fans, household items and furnishings;
(5) Emergency facility services for non-emergencies;
(6) Out-of-state emergency and non-emergency services;
(7) Experimental and investigational services, procedures, drugs, devices, and treatments;
(8) Organ and tissue transplantation and transplantation services for either a recipient or a donor;
(9) Blood, blood products, and blood storage on an outpatient basis;
(10) Gender reassignment and related medical, surgical, and psychiatric services, drugs, and hormones;
(11) In vitro fertilization, reversal of sterilization, artificial insemination, sperm banking procedures, and drugs to test fertility;
(12) Eyeglasses, contact lenses, low vision aids, orthoptic training, and refractions;
(13) Hearing aids and related supplies and services, including fitting for, purchase of, rental of, and insuring of hearing aids;

(14) Durable medical equipment, protheses, orthoses, medical supplies, and related services including purchases, rental, repairs, and related services, except as supplied as part of an inpatient hospital stay;
(15) All dental services, including orthodontic services and supplies, except emergency dental services as defined in this subchapter;
(16) Biofeedback, acupuncture, naturopathic services, faith healing, Christian Science services, hypnosis, massage treatment;
(17) Obesity treatment, weight loss programs, food, food supplements, health foods, and prepared formulas;
(18) All services, procedures, equipment, supplies not specifically listed which are not medically necessary;
(19) Cosmetic surgery or treatment, cosmetic rhinoplasties, reconstructive or plastic surgery to improve appearance and not bodily function, piercing of ears and other body areas, electrolysis, hair transplantation, reduction and augmentation mammoplasties, paniculectomies and other body sculpturing procedures, excision or destruction of benign skin or subcutaneous lesions without medical justification;
(20) Transportation including air (fixed wing or helicopter) ambulances;
(21) Hospice services;
(22) All home health agency services;
(23) Personal care, chore services, adult day health, private duty nursing, social worker services, case management services, targeted case management services, and community care long term care branch services;
(24) Funeral payment services;
(25) Tuberculosis services when provided without cost to the general public;
(26) Hansen's disease treatment or follow-up;
(27) Treatment of persons confined to a public institution;
(28) Penile and testicular prostheses and related services;
(29) Chiropractic services;
(30) Psychiatric care and treatment for sex and marriage problems; weight control, employment

counseling, primal therapy, long term character analysis, marathon group therapy, and consortium;

(31) Routine foot care and treatment of flat feet;

(32) Swimming lessons, summer camp, gym membership, weight control classes;

(33) Outpatient renal dialysis, cardiac and coronary artery surgery involving cardio-pulmonary by-pass, cataract surgery with or without intraoccular lens implants, and refractive keratoplasty;

(34) Physical therapy, occupational therapy, speech therapy, respiratory services, and sleep studies rendered on an outpatient basis;

(35) Medical services provided without charge by any other federal, state, municipal, territorial, or other government agency including the Veterans Administration;

(36) Medical services for an injury or illness caused by another person or third party from whom the enrollee has or may have a right to recover damages;

(37) Medical services that are payable under the terms of any other group or non-group health plan overage;

(38) Medical services that do not follow standard medical practice or are not medically necessary;

(39) Stand-by services by a stand-by physician and telephone consultation;

(40) Services provided for illness or injury caused by an act of war, whether or not a state of war legally exists, or required during a period of active duty that exceeds thirty days in any branch of the military;

(41) Treatment of sexual dysfunction including medical and surgical procedures, supplies, drugs, and equipment;

(42) All services excluded by the Hawaii Medicaid Program;

(43) All services not provided by providers licensed or certified in the State of Hawaii to perform the service;

(44) Medical services that are payable under terms of worker compensation, automobile medical and no-fault, underinsured or uninsured motorist, or similar contract of insurance;

(45) Physical examination required for continuing employment, such as taxi driver's or truck driver's licensing, or as required by government or private businesses;
(46) Physical examinations, psychological evaluations, and immunizations as a requirement for licenses or for purposes of securing insurance policies or plans;
(47) Allergy testing and treatment;
(48) Treatment of any complication resulting from previous cosmetic, experimental, investigation service, or any other non-covered service;
(49) Rehabilitation services requiring intensive continuous care, inpatient or outpatient, including cardiac, alcohol or drug dependence rehabilitation;
(50) All acne treatment, surgery, drugs for adults; removal or treatment of asymptomatic benign skin lesions or growth; and
(51) Prenatal, postpartum, and delivery services including all laboratory testing in both inpatient and outpatient setting. An exception is one outpatient visit to confirm pregnancy, as identified as a covered service in this chapter. [Eff 03/30/96; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-20 Dental services for adults in QUEST-Net. (a) Dental services for an individual age twenty-one or older in QUEST-Net shall be limited to emergency treatments which do not include services aimed at restoring or replacing teeth and shall include services for the following:
(1) Relief of dental pain;
(2) Elimination of infection; and
(3) Treatment of acute injuries to the teeth and supporting structures of the oro-facial complex.
(b) An individual age twenty-one or older in QUEST-Net shall select and be enrolled in a participating dental plan through which coverage of emergency dental treatment shall be provided. [Eff 03/30/96; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-21 Reimbursement to participating medical and dental plans. (a) Each participating plan shall be paid on a capitated basis, as negotiated with the department, for individuals enrolled in the plan.

(b) The department shall provide the capitated payment, as stipulated in the contract between the department and each participating plan, in return for the plan's provision of all contracted coverage for the plan's enrollees. [Eff 03/30/96] (Auth: HRS §346-14) (Imp: HRS §346-16; 42 C.F.R. §430.25)

§17-1728-22 Enrollment of adults in QUEST-Net medical and dental plans. (a) An adult who was enrolled in a QUEST plan prior to participating in QUEST-Net shall be enrolled in the QUEST-Net plan administered by the health coverage carrier which administered the QUEST plan in which the person was enrolled.

(b) If an adult was enrolled in a QUEST plan administered by a health coverage carrier which does not participate in QUEST-Net, the adult shall select and be enrolled in a QUEST-Net plan serving the area of the adult's residence.

(c) An adult who participated in QUEST prior to QUEST-Net but was not enrolled in a QUEST plan shall select and be enrolled in a participating QUEST-Net plan serving the area of the adult's residence.

(d) An adult who is disenrolled from a QUEST-Net plan shall be allowed to select a plan of their choice if disenrollment extends for three or more consecutive calendar months in a benefit year.

(e) An adult who participated in the fee for service QUEST-Spenddown program or coverage for aged, blind, and disabled individuals prior to QUEST-Net, shall select and be enrolled in a participating QUEST-Net plan serving the area of the person's residence.

(f) To the extent possible under the rules of this chapter, all eligible members of a family participating in QUEST-Net shall be enrolled in the same medical and dental plans. [Eff 03/30/96; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-23 Initial enrollment in QUEST-Net medical and dental plans. (a) An adult, who was not enrolled in a QUEST plan prior to QUEST-Net

participation, shall be allowed ten days to select a QUEST-Net plan.

(b) An adult, who was enrolled in a QUEST plan administered by a health coverage carrier that does not administer a QUEST-Net plan, shall be allowed ten days to select a QUEST-Net plan.

(c) An adult who fails to select a QUEST-Net plan within ten days shall be deemed ineligible for QUEST-Net participation. [Eff 03/30/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-24 Effective date of enrollment. (a) For an adult who participated in the fee for service QUEST-Spenddown program or coverage for aged, blind, and disabled individuals, the effective date of QUEST-Net enrollment shall be the first day of the month after the adult's fee for service coverage is terminated.

(b) For an adult enrolled in a QUEST plan, the effective date of QUEST-Net enrollment shall be the first day of the month after the last day of coverage by the QUEST plan.

(c) For a QUEST recipient who was not enrolled in a QUEST plan, the effective date of QUEST-Net enrollment is the date the enrollment process has been completed to enroll the adult in a QUEST-Net plan. [Eff 03/30/96; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-25 Changes from one QUEST-Net plan to another. (a) An enrollee shall only be allowed to change from one QUEST-Net plan to another during the annual QUEST-Net open enrollment period.

(1) Exceptions to the preceding provision include decisions from administrative hearings, legal decisions, termination of plan contract, or mutual agreement by the medical plans involved, the enrollee, and the department.

(2) Reasons for the exceptions in paragraph (1) include efforts to enroll reconciled or newly formed families into the same plan, change of residence by an enrollee from one service area to another, and other special circumstances.

(b) The annual QUEST-Net open enrollment period shall occur in May of each calendar year.

(c) An enrollee who is enrolled in a non-returning plan shall be allowed to select from the available plans.

(d) If the enrollee is required to select a plan, but does not select a plan during the open enrollment period, enrollment in a health plan shall be assigned by the department.

(e) Changes in enrollment resulting from an open enrollment period shall be implemented effective the first day of July of that calendar year and shall generally extend to June 30 of the following calendar year. [Eff 03/30/96; am 11/25/96; am 06/19/00] (Auth: HRS §346-14) (Imp HRS §346-14; 42 C.F.R. §430.25)

§17-1728-26 Financial responsibility of adult enrollees. (a) An adult enrollee may be responsible for payment of the capitated cost paid by the department to a participating plan for the enrollee's coverage. This payment required of the enrollee shall be known as the premium-share.

(b) An enrollee who is assessed a premium-share shall pay the amount to the department by the tenth day of the benefit month.

(c) An adult enrollee, with the exception of a self-employed adult and spouse, whose countable family income exceeds one hundred per cent of the federal poverty level for a family of applicable size shall be responsible for a premium-share equal to the total cost of the enrollee's coverage under QUEST-Net.

(d) An adult enrollee, with the exception of a self-employed adult and spouse, whose countable family income does not exceed one hundred per cent of the federal poverty level for a family of applicable size shall not be responsible for a premium-share.

(e) An adult who is self-employed and the spouse of a self-employed adult shall be responsible for:

(1) A premium-share equal to fifty per cent of the total cost of coverage under QUEST-Net if the countable family income is equal to or less than one hundred per cent of the federal poverty level for a family of appropriate size; or

(2) A premium-share equal to the total cost of the enrollee's coverage under QUEST-Net if the countable family income exceeds one hundred per cent of the federal poverty level for a family of applicable size; and

(3) Co-payments for certain kinds of services described in this section, without regard to the amount of countable family income.

(f) A maximum of five enrollees in a family shall be assessed a premium-share for QUEST or QUEST-Net coverage by the department in the following manner:

(1) Determine the number of persons in a family eligible for QUEST or QUEST-Net coverage who are responsible for a premium-share; and

(2) Assess premium-shares to a maximum of five enrollees in descending order by date of birth.

(g) An enrollee age twenty-one or older, who is responsible for a premium-share shall be responsible for specified dollar amounts, known as co-payments, for certain kinds of services. The following are the dollar amounts of the co-payments and the services related to the co-payments:

(1) Twenty-five dollars per visit for outpatient hospital emergency room services with co-payments being waived for emergency situations;

(2) Seven dollars per visit for urgent care services;

(3) Seven dollars per visit for outpatient physicians services;

(4) Two dollars per prescription for prescribed generic or single-source brand drug; and

(5) Five dollars per prescription for multiple-source brand drug. [Eff 03/30/96; am 11/25/96; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-27 Disenrollment from QUEST-Net plans. (a) The department shall have sole authority to disenroll a QUEST-Net enrollee.

(b) An individual who does not meet the QUEST-Net eligibility requirements shall be disenrolled from the QUEST-Net plan in which the individual is enrolled.

(c) The department may disenroll an enrollee for reasons which include, but are not limited to, the following:

(1) The individual's or family's designated premium-share payments for QUEST or QUEST-Net coverage are two months in arrears;

(2) To comply with an administrative appeal decision or a court order;

(3) The department's concurrence with a medical or dental plan's recommendation for disenrollment when appropriate;
(4) A mutual agreement between the individual, the medical or dental plans involved, and the department; or
(5) An individual's voluntary withdrawal from participation in QUEST-Net. [Eff 3/30/96; am 11/25/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-28 Requests from a medical or dental plan for disenrollment. (a) A medical or dental plan may request disenrollment of an enrollee for reasons which include, but are not limited to, the following:
(1) Chronic refusal by an enrollee to pay the plan for the required service specific co-payments described in this chapter; or
(2) Chronic abusive behavior on the premises of a plan's providers, against the provider staff, other patients, or other individuals.

(b) A plan shall ensure that the enrollee is afforded sufficient opportunity to correct such behavior prior to recommending disenrollment.

(c) A plan shall provide the enrollee sufficient opportunity to present the enrollee's case through the plan's grievance procedures, as specified in the contract between the plan and the State, prior to recommending disenrollment.

(d) Upon exhausting avenues of reconciliation of problems with an abusive enrollee, a plan may submit a recommendation for disenrollment to the department.

(e) A plan shall provide the enrollee adequate advance notice of the plan's intent to recommend disenrollment. [Eff 11/25/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-29 Requirements of QUEST-Net recipients requesting a change in coverage to QUEST or the fee for service coverage for the aged, blind and disabled. (a) A QUEST-Net recipient may verbally request a change in coverage to QUEST or the fee for service coverage for the aged, blind and disabled as applicable.

(b) The recipient shall be given fifteen calendar days to provide a written request for such change in coverage.

(c) Upon the timely submittal of a written request, the date of a verbal request for coverage shall be the effective date of QUEST coverage. The effective date of fee for service coverage shall be the first day of the month in which the verbal request was received.

(d) The request to change health coverage shall be denied if a written request is not received within fifteen calendar days. The recipient's coverage in QUEST-Net shall continue, if the recipient continues to meet the QUEST-Net eligibility requirements. [Eff 11/25/96; am 02/10/97; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1728-30 to 1728-31 (Reserved)

SUBCHAPTER 4

CHILDREN IN QUEST-NET WHO ARE NOT BLIND OR DISABLED

§17-1728-32 Purpose. The purpose of this subchapter is to describe the children formerly eligible under QUEST-related programs who are eligible to participate in QUEST-Net, the benefits to be provided, enrollment provisions, and financial responsibility of enrollees for coverage of health care costs. [Eff 03/30/96; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-33 Children who are not disabled or blind. A child who is not blind or disabled may be eligible for QUEST-Net if the child becomes ineligible for a QUEST-related program. The following may be reasons for the child to become ineligible for a QUEST-related program:

(1) The child does not meet the financial eligibility requirements of the QUEST-related program; or

(2) The child or the child's representative may have voluntarily requested termination of QUEST-related program coverage.

[Eff 03/30/96; am 12/27/97; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-34 QUEST-Net coverage for children who are not blind or disabled. (a) The benefits provided under the QUEST standard benefits package for an individual under age twenty-one as described in chapter 17-1727 shall be provided for an individual under age twenty-one in QUEST-Net who are not blind or disabled.

(b) If eligible for QUEST-Net, a child who is not blind or disabled, shall be enrolled in participating health care plans.

(c) If a child was enrolled in a QUEST plan, the child shall be enrolled in a QUEST-Net plan administered by the health coverage carrier that administers the QUEST plan in which the child was enrolled.

(d) A child who is disenrolled from a QUEST-Net health plan shall be allowed to select a plan of their choice if disenrollment extends for three or more consecutive calendar months in a benefit year.

(e) If a child was not enrolled in a QUEST plan, the child or the child's representative shall be allowed ten days to select a QUEST-Net plan in which to enroll the child. A child for whom a QUEST-Net plan is not selected within ten days shall be deemed ineligible for QUEST-Net participation.

(f) A child or the child's representative shall only be allowed to change from one QUEST-Net plan to another during the annual QUEST-Net open enrollment period.

(1) Exceptions to the preceding provision include decisions from administrative hearings, legal decisions, termination of plan contract, or mutual agreement by the medical plans involved, the enrollee, and the department.

(2) Reasons for the exceptions in paragraph (1) include efforts to enroll reconciled or newly formed families into the same plan, change of residence by an enrollee from one service area to another, and other special circumstances.

(g) The annual QUEST-Net open enrollment period shall occur in May of each calendar year.

(h) A child who is enrolled in a non-returning plan shall be allowed to select from the available plans.

(i) If the child or the child’s representative is required to select a plan, but does not select a plan during the open enrollment period, enrollment in a health plan shall be assigned by the department.

(j) Changes in enrollment resulting from an open enrollment period shall be implemented effective the first day of July of that calendar year and shall generally extend to June 30 of the following calendar year. [Eff 03/30/96; am 11/25/96; am 06/19/00] (Auth: HRS §346-14) (Imp HRS §346-14; 42 C.F.R. §430.25)

§17-1728-35 Reimbursement to participating plans. (a) Each participating plan shall be paid on a capitated basis, as negotiated with the department, for children enrolled in the plan.

(b) The department shall provide the capitated payment, as stipulated in the contract between the department and each participating plan, in return for the plan's provision of all contracted coverage for the plan's enrollees. [Eff 03/30/96] (Auth: HRS §346-14) (Imp: HRS §346-16; 42 C.F.R. §430.25)

§17-1728-36 Financial responsibility of child enrollees. (a) A child enrollee may be responsible for payment of the capitated cost paid by the department to a participating plan for the enrollee's coverage. This payment required of the enrollee shall be known as the premium-share.

(b) An enrollee who is assessed a premium-share shall pay the amount to the department by the tenth day of the benefit month.

(c) A child enrollee whose countable family income exceeds one hundred per cent of the federal poverty level for a family of applicable size shall be responsible for a premium-share equal to a total of the capitated rates paid for QUEST-Net medical and dental adult coverage.

(d) An child enrollee whose countable family income does not exceed one hundred per cent of the federal poverty level for a family of applicable size shall not be responsible for a premium-share.

(e) A maximum of five enrollees in a family shall be assessed a premium-share for QUEST or QUEST-Net in the following manner:

(1) Determine the number of persons in a family eligible for QUEST or QUEST-Net coverage who are responsible for a premium-share; and

(2) Assess premium-shares to a maximum of five enrollees in descending order by date of birth. [Eff 03/30/96; am 11/25/96]

(Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-37 Disenrollment from QUEST-Net plans. (a) The department shall have sole authority to disenroll a QUEST-Net enrollee.

(b) An individual who does not meet the QUEST-Net eligibility requirements shall be disenrolled from the QUEST-Net plan in which the individual is enrolled.

(c) The department may disenroll an enrollee for reasons which include, but are not limited to, the following:

(1) The individual's or family's designated premium-share payments for QUEST or QUEST-Net coverage are two months in arrears;

(2) To comply with an administrative appeal decision or a court order;

(3) A mutual agreement between the child's representative, the medical or dental plans involved, and the department; or

(4) A voluntary withdrawal from participation in QUEST-Net by the child's representative. [Eff 03/30/96; am 11/25/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1728-38 to 17-1728-40 (Reserved)

SUBCHAPTER 5

BLIND AND DISABLED CHILDREN IN QUEST-NET

§17-1728-41 Purpose. The purpose of this subchapter is to describe the blind and disabled children formerly eligible under the fee for service coverage for blind and disabled recipients or under QUEST-related programs who are eligible to participate in QUEST-Net, the benefits to be provided, and their financial responsibility for coverage of health care costs. [Eff 03/30/96; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-42 Blind or disabled children who become ineligible for fee for service coverage. A blind or

disabled child may become ineligible for fee for service coverage as a blind or disabled medical assistance recipient for the following reasons:

(1) The child's countable family assets exceeded allowable retention amounts; or

(2) The child or the child's representative voluntarily requested termination of fee for service coverage as a blind or disabled child. [Eff 03/30/96] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1728-43 Children who become ineligible for QUEST-related program and the fee for service coverage for the blind or disabled. A child may become ineligible for a QUEST-related program when the child is certified to be blind or disabled. The child may also be ineligible for fee for service coverage as a blind or disabled person for the following reasons:

(1) The child cannot meet the financial eligibility requirements of the medical assistance program for the blind and disabled; or

(2) The child or the child's representative voluntarily requested termination of fee for service coverage as blind or disabled child. [Eff 03/30/96; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-44 QUEST-Net coverage for blind and disabled children. (a) The benefits provided under the fee for service medical assistance program for an individual under age twenty-one as described in chapter 17-1737 shall be provided for an individual under age twenty-one in QUEST-Net who are blind or disabled.

(b) If eligible for QUEST-Net, these children certified as blind or disabled shall receive medical and dental coverage on a fee for service basis. [Eff 03/30/96; am 06/19/00] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728-45 Financial responsibilities of blind and disabled children in QUEST-Net. (a) A blind or disabled child in QUEST-Net shall not be responsible for any share of the cost of the child's medical and

dental coverage if the child's countable family income does not exceed one hundred per cent of the federal poverty level for a family of applicable size.

(b) A blind or disabled child whose countable family income exceeds the federal poverty level for a family of applicable size shall be responsible for a share of the child's monthly medical expenses.

(c) When determining the child's share of monthly medical expense, the child's family income shall be treated as income is treated in the Hawaii QUEST program, as described in chapter 17-1727.

(d) The dollar amount by which the child's family income exceeds one hundred per cent of the poverty level for a family of applicable size shall be known as the monthly spenddown requirement.

(e) Notwithstanding the provisions of subsection (d), the monthly spenddown requirement of a child in QUEST-Net shall not exceed the dollar amount equal to the combined capitated cost of QUEST-Net medical and dental coverage for an adult QUEST-Net enrollee.

(f) Of the child's monthly health care costs, the family shall be responsible for an amount equal to the monthly spenddown requirement, before coverage under the QUEST-Net program. [Eff 03/30/96] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)